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No. 93-510

IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

AETNA LIFE INSURANCE COMPANY and
AETNA HEALTH MANAGEMENT,

Petitioners,

—v.—

STUART CIRCLE HOSPITAL CORPORATION,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE FOURTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF FOR METROPOLITAN LIFE INSURANCE COMPANY AS AMICUS CURIAE AND BRIEF AMICUS CURIAE IN SUPPORT OF PETITIONERS

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MOTION FOR LEAVE TO FILE BRIEF FOR METROPOLITAN LIFE INSURANCE COMPANY AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

Metropolitan Life Insurance Company ("MetLife") hereby moves, pursuant to Rule 37.2 of the Rules of this Court, for leave to file the attached brief as *amicus curiae*. Counsel for the petitioner has consented to the filing of this brief; counsel for the respondent has denied consent.

MetLife is one of the largest group insurers and claims administrators in the United States. Many of its customers conduct business national in scope and provide benefits to employees located in virtually every state of the United States. MetLife, for the benefit of those customers and their employees, supports and maintains preferred-provider networks or programs in Virginia and across the country. A substantial portion of the day-to-day decisions MetLife makes are therefore subject to federal-question jurisdiction under the Employee Retire-

ment Income Security Act of 1974, as amended ("ERISA"), because they relate to employee welfare benefit plans within ERISA's ambit. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 67 (1987).

MetLife, as an insurer affected by ERISA, has steadfastly sought to preserve the intent of Congress in enacting ERISA, as evidenced by the preceding legal citation. Congress intended ERISA to eliminate the need for employers to design employee welfare benefit plans according to a varying patchwork of state regulation. 3 Legislative History of the Employee Retirement Income Security Act of 1974 at 4673 (1976). Toward that end, it gave ERISA one of the broadest pre-emption clauses contained in any federal statute. ERISA pre-empts any state law which "relate[s] to *any* employee benefit plan" not explicitly exempt from ERISA. ERISA § 514(a) (emphasis added). While it saves from pre-emption state laws which "regulate[ ] insurance," ERISA § 514(b)(2)(A), it does so narrowly, without compromising the "conspicuous" breadth of the pre-emption clause. *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990).

The central issue in this case—whether Virginia's any-"willing"-provider law is saved from ERISA pre-emption—is one in which MetLife is vitally interested. Under the Virginia statute, if a health care provider is "willing" to enter into a contractual relationship with an insurer that establishes a preferred-provider program, then the provider must be allowed to enter into that relationship, unless "[ ]reasonable discrimination" can be shown. *See* VA. Code Ann. § 28.1-2307(A), (B). The Fourth Circuit held that the statute—which mandates a contractual relationship between two business entities, one of which happens to be an insurer—regulates insurance and is therefore saved from ERISA pre-emption. 995 F.2d at 505. Because MetLife, for the reasons set forth in the attached brief *amicus curiae*, firmly believes that Virginia's any-"willing"-provider law does *not* regulate insurance but inhibits the ability of plan sponsors to engage in creative, uniform ERISA plan design,

MetLife asks this Court to grant this motion for leave to file the attached brief, in support of the Petition.

Dated: October 28, 1993

Respectfully submitted,

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QUESTION PRESENTED

Is Virginia's any-"willing"-provider law saved from ERISA pre-emption because it "regulates insurance," as that phrase has been interpreted by controlling precedent of this Court, or, because it *fails* to "regulate[ ] insurance," does ERISA in fact pre-empt it?

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INTEREST OF AMICUS

MetLife has one of the largest preferred-provider programs in the nation and operates a preferred-provider program in the State of Virginia. That program functions according to a universally-accepted premise: Some providers are willing to supply services to patients at lowered rates in exchange for the presumption of increased volume. Conversely, some beneficiaries of group health insurance contracts are willing to forgo utilization of their usual provider in favor of a "preferred provider" if the cost to them of doing so will be reduced.

In a preferred-provider program, it is a truism that the volume handled by each provider increases when there are fewer

providers to choose from. The larger the number of providers in a particular geographical area, the less likelihood there is that any particular provider will be chosen by the beneficiaries who reside in that locale, and the less inducement there will be for local providers to exchange lowered rates for the presumption of increased volume. Indeed, if, under the statute challenged here, all local providers were to participate voluntarily in such a program, the cost-control aspect of the program would, in the end, fail. With elimination of the presumption of increased volume, the reason for joining the program would cease to exist. Under the latter scenario, such a program could continue only if all providers were required to supply services at a reduced rate, regardless of volume.

The ruling of the Fourth Circuit Court of Appeals in *Stuart Circle Hospital Corp. v. Aetna Health Management*, 995 F.2d 500 (1993), which wrongly interpreted section 38.2-3407 of the Virginia Code, gives providers the best of both worlds and insurers the best of none. Providers are not required to supply their services at a reduced rate, but insurers are required to admit them to their preferred-provider networks, whether or not they would otherwise be accepted, thereby diluting the potential to generate volume and cost savings through a limited preferred-provider program. In the end, the Fourth Circuit's decision, which conflicts with prior decisions of this Court, gives providers the means of destroying the very networks which the Virginia Code purports to authorize by undermining the rationale of such networks and inhibiting sponsors of ERISA plan from engaging in effective plan design. Because MetLife believes that no such result is required or permitted under ERISA, it submits this brief in support of the petition.

REASONS FOR GRANTING WRIT

A. The Decision of the Fourth Circuit Impermissibly Expands ERISA's Saving Clause at the Expense of its Pre-Emption Clause, in Contravention of Controlling Precedent of This Court.

This Court should issue a writ of *certiorari* to the United States Court of Appeals for the Fourth Circuit because the latter's opinion in *Stuart Circle v. Aetna* has decided a federal question, restricting the scope of ERISA's pre-emption clause, in a way which conflicts with controlling decisions of this Court. *See* Sup. Ct. Rule 10.1(c).

The extent to which ERISA pre-empts "any and all State laws" that "relate to" an ERISA plan is a federal question. See ERISA § 514(a); *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 67 (1987). This Court has previously decided that ERISA's pre-emption clause is "conspicuous" for its breadth and must be broadly construed, to the fullest limits. *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990); *see also Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47-48 (1987).

Although ERISA "saves" from pre-emption those state laws which "regulat[e] insurance, banking, or securities," § 514(b)(2)(A), in comparison to the "all-inclusive pre-emption provision," the savings-clause exceptions are "specific" and "narrow." *Shaw v. Delta Air Lines*, 463 U.S. 85, 104 (1983). Prior precedent of this Court therefore requires that the *pre-emption* clause be *broadly* construed while the "*saving*" clause be given a "*narrow*" reading, limited to its specific exceptions. *Pilot Life*, 481 U.S. at 47-48; *Shaw*, 463 U.S. at 104 (emphasis added). To ensure that dichotomy of treatment, this Court has developed two tests which state laws purporting to "regulat[e] insurance" must pass or they will not be saved from ERISA pre-emption: (1) the "common-sense" test; and (2) the McCarran-Ferguson Act test. *Pilot Life*, 481 U.S. at 48-49. By wrongly finding that Virginia's any-"willing"-provider law sat-

isfies both tests, 995 F.2d at 503, the Fourth Circuit "broadly" construed ERISA's "saving" clause at the expense of its pre-emption clause, in contravention of this Court's controlling precedents.

According to this Court, common sense dictates that "in order to regulate *insurance* [and, as a result, be saved from ERISA pre-emption], a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry." *Pilot Life*, 481 U.S. at 50. As this Court observed in *Pilot Life*, if a law having an impact on the insurance industry nevertheless has its roots "firmly planted in the general principles of . . . tort *and contract law*," it will fail to satisfy the common-sense test. 481 U.S. at 50 (emphasis added). The Fourth Circuit nevertheless declared that Virginia's any-"willing"-provider law *had* satisfied the common-sense test because "it regulates *certain insurance contracts*, albeit indirectly[.]" 995 F.2d at 503.

What the Fourth Circuit neglected to point out is that the true focus of Virginia's any-"willing"-provider law is *providers*, not insurers. Because the statute requires an insurer to enter into a contract with *any provider* "*willing* to meet [its] terms and conditions" (notwithstanding the statute's claim that an insurer may "limit" the number of providers with which it may contract), the statute gives *providers* a right they would not ordinarily have, absent the statute. VA. Code Ann. § 28.1-2307(A), (B) (emphasis added). By mandating a contractual relationship between parties where no meeting of the minds would otherwise occur, the roots of this Virginia statute extend directly into general principles of *contract* law, not insurance law, as did the Mississippi law of "bad faith" pre-empted in *Pilot Life*. *See* 481 U.S. at 50. Nothing commonly thought of as "*insurance*" or an "*insurance* contract" results from an insurance company entering into a contract with a health-care provider to supply services at a specified rate, or from a provider obtaining a guaranteed right to enter into such a contract with an insurer, any more than "insurance" would result from a statutorily-man-

dated purchase of paper clips from a company willing to match the price of an insurer's existing vendor. As a matter of "common sense," the Virginia statute doesn't "regulat[e] insurance," it regulates the contractual relationship between two business entities, one of which happens to be an insurer. As a matter of common sense, Virginia's any-"willing"-provider law therefore falls outside the "narrow" scope of ERISA's saving clause. *Shaw*, 463 U.S. at 104; ERISA § 514(b)(2)(A). It is preempted. *Pilot Life*, 481 U.S. at 50; ERISA § 514(a).

Virginia's any-"willing"-provider law also fails to satisfy any prong of the McCarran-Ferguson Act test. To satisfy that test, the law in question must (1) transfer or spread *policyholder risk*; (2) be integral to the policy relationship between the *insurer* and the *insured*; and (3) relate to a "practice" which is limited to entities within the insurance industry. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743 (1985).

No risk to any policyholder (or plan participant) is spread by the Virginia statute. The statute does not *require* insurers to offer participants the benefits of a preferred provider program, it only specifies that *if* the insurer has such a program, then provider X, if willing, must be given the same contractual opportunity to provide services to plan participants as provider Y. VA. Code Ann. § 28.1-2307(B). The fact that X rather than Y might be the provider of services (even if supplied at a reduced rate) does not spread anyone's *risk* of loss, it merely explains who the provider can or will be. *See Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129-130 (1982).

Furthermore, while this Court has held that health-care benefits mandated by law *do* spread or transfer policyholder risk within the meaning of the first prong of the McCarran-Ferguson Act test, *Metropolitan v. Massachusetts*, 471 U.S. at 744, the Virginia statute does not mandate a benefit to any *plan participant*. A "mandated benefit" is "a certain *kind* of benefit" (such as benefits for mental hygiene) which an insurer must

provide to the *beneficiaries* of an *insurance* contract, under all circumstances. 471 U.S. at 728-30.

The Virginia any-"willing"-provider law operates in a completely different way. It mandates no *kind* of benefit to the beneficiaries of group insurance contracts. Indeed, it is entirely conceivable that, after application of the Virginia statute, one beneficiary could go to his or her chosen provider and obtain covered services from a "preferred provider" at a reduced rate while another beneficiary of the same contract could go to his or her chosen provider and obtain covered services but be required to pay full cost. Why? Because the participant's ability to benefit from application of the Virginia statute turns on the *whim of the provider* in being "willing" to enter into a preferred provider agreement with the insurer. The statute does not mandate *anything* with respect to the intended third-party beneficiaries of a group insurance contract. Rather, it mandates a contractual relationship between insurers and certain providers who are *not* the intended third-party beneficiaries of any such contract. Hence, the Virginia statute fails to transfer any risk, whether one performs traditional risk analysis or analyzes the statute as a mandated-benefit law under the controlling precedent of *Metropolitan v. Massachusetts*.

Nor does Virginia's any-"willing"-provider law affect the relationship between the insurer and *the insured*, as evidenced by the caption to this lawsuit where only the names of a hospital and an insurer appear. Health care *providers*—not plan participants—have sued to obtain what they argue are *their* mandated rights. The law at issue clearly affects the relationship between the *insurer* and the *provider*, not the insurer and the insured.

Finally, although the Virginia any-"willing"-provider law purports to focus on the insurance industry, the practice of entering into contracts with providers is hardly a "practice . . . limited to entities within [that] industry." *See Pilot Life*, 481 U.S. at 51. The crux of the matter here is the contractual

relationship between one group of business people—*providers*—and those from another business—in this case, insurers. Entering into contractual relationships with providers is a "practice" no more limited to the insurance industry than was the bad-faith law pre-empted in *Pilot Life*. *Id.* Hence, the Virginia any-"willing"-provider law fails to satisfy any prong of the McCarran-Ferguson Act test and is not saved from ERISA pre-emption. *See Pilot Life*, 481 U.S. at 50-51.

B. The Decision of the Fourth Circuit Impermissibly Inhibits ERISA Plan Design, While Congress, in Enacting ERISA, Sought to Avoid the Kind of Piecemeal State Regulation Which the Fourth Circuit's Decision Promotes.

There is, ultimately, another over-arching reason why Virginia's any-"willing"-provider law should be pre-empted. That law attempts to regulate ERISA plan design, not to mandate benefits. ERISA was intended to *eliminate* the need for plan sponsors "to design their programs in an environment of differing State regulations . . . ." *FMC Corp.*, 498 U.S. at 60. It is important to keep that objective in mind, particularly when the saving clause is utilized to limit plan design in a way which Congress never intended, for "in interpreting the saving clause, [courts are obliged] to consider [its] role . . . in [the context of] ERISA as a whole." *Pilot Life*, 481 U.S. at 51.

The statute here in question limits an insurer's ability to design an efficacious plan yet fails to pass the tests, established by this Court, which show that it should be "saved" from the broad sweep of ERISA pre-emption. In the greater context of what Congress hoped to achieve by enacting ERISA, that statute not only "relate[s] to" an ERISA plan but is precisely the kind of overreaching statute which ERISA was designed to pre-empt. *Pilot Life*, 481 U.S. at 51-52; *Shaw*, 463 U.S. at 104.

CONCLUSION

Under controlling precedent of this Court, Virginia's any-"willing"-provider law fails to "regulate[ ] insurance" and therefore is pre-empted, without being saved. Because the Fourth Circuit, in *Stuart Circle*, found that Virginia's any-"willing"-provider law was "saved" from ERISA pre-emption, it should be *reversed*.

October 28, 1993

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